PATIENT EDUCATION IN PRIMARY CARE:
KEY TO ACTIVE VETERAN PARTICIPATION

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WELCOME to our new resource for patient education and primary care![1]

- WHAT IS IT? The purpose of this tool is to provide a mechanism to help meet the challenges of incorporating effective patient teaching into primary health care.
- WHO IS IT FOR? VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decisionmakers

CHALLENGES OF IMPLEMENTING SCREENING FOR DEPRESSION IN PRIMARY CARE CLINICS

The EPRP requirement to complete a depression screening (using a valid and reliable tool) for all veterans once a year has required creative problem solving to implement successfully. At the Grand Junction VAMC for example, primary care providers have spent a year modifying their approach in order to improve patient response and the reliability of the results. The current screening

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Figure 1

Depression

Depression can have a number of different symptoms such as feeling sad or blue. Being sick can cause depression and depression can make other conditions worse

Each patient needs to answer these 5 questions on how they have felt during the past week.

FOR STAFF USE ONLY

1_____
2_____
3_____
4_____
5_____
T _____

During the past week:

1. I felt that I could not shake off the blues even with help from family or friends (circle) → ZERO days, 1 2 3 4 5 6 7 days.
2. I felt depressed. (circle) → ZERO days, 1 2 3 4 5 6 7 days.
3. I felt fearful. (circle) → ZERO days, 1 2 3 4 5 6 7 days.
4. My sleep was restless. (circle) → ZERO days, 1 2 3 4 5 6 7 days.
5. I felt hopeful about the future (circle) → 7 6 5 4 3 2 1 0 days.

Do you have future appointments in Mental Hygiene Clinic? Yes ___ No ___

[1]**This publication may be duplicated. It is also available on the VA website at http://www.va.gov/visns/visn02/emp/education/education.html.**

[2]*For reliability and validity information see Lewinsohn, P.M. et al. (1997) Center for Epidemiologic Studies Depression Scale (CES-D) as a screening instrument for depression among community-residing older adults. Psychology and Aging. 12(2):227-287.*

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tool (Figure 1[2]) is included in a two page To Your Good Health assessment and education form that is completed by all veterans once a year. This form also includes brief assessments for alcohol abuse, smoking and interest in quitting, advance directives, vaccinations, and interest in nutrition education interspersed with prevention recommendations. During the intake process a healthcare provider reviews the completed form with the patient. Laminated scoring criteria for the depression screen are posted in all of the exam rooms to facilitate easy use; anyone scoring > 4 is referred to social service for a more in-depth assessment.

STEP 1: Initially the depression screening was done by social work staff. A nurse or physician first completed a broad mental health screen and then the veteran was referred to social work for the mood disorder or depression screen. A tool similar to the final patient administered screen was used; however, the social worker actually asked the questions. In the words of clinic staff this protocol was a logistic nightmare. Patients did not want to extend their time in the clinic for an additional screen; social work staff were not always available during primary care clinic hours to complete the screening.

STEP 2: The depression screen became a self-administered tool that was handed out to veterans as a separate sheet of paper with the To Your Good Health Assessment. The title of the screen was changed to "Evaluation of Stress Level". In general veterans were very confused by this screen and didn't want to fill it out. They felt that everyone had stress in their lives and didn't see how the questions related to stress. Staff also didn't like the fact that there was yet another piece of paper for the chart.

STEP 3: The screen was retitled "Depression" and incorporated into the To Your Good Health Assessment. A question was added at the end of the screen asking if the patient had future appointments in the Mental Hygiene Clinic--this would identify those who were already in treatment. Since veterans were having trouble understanding from the way the questions was written that they needed to choose the number of days that corresponded with their feeling depressed or fearful, the response categories were changed. Originally, the respondent would chose the number of days per week and write it in the blank-- _____(0-7) days. Each of the screening items was changed to the following format:

2. I felt depressed (circle) No days 1 2 3 4 5 6 7 days

STEP 4: Staff noticed that veterans did better with the screen if they actually filled it out by themselves. If a primary care provider was available, they tended to ask questions like "what do you mean hopeful about the future?" As with other questions on the assessment form there was a tendency for some veterans to provide the answer they thought staff wanted. Patients also seemed confused by the substitution of the words "no days" for 0 days.

STEP 5: A minor change was made replacing "No days" with "ZERO days." By this time, veterans were getting accustomed to the new screen; the clerical staff were also more comfortable reminding veterans to fill it out completely. The current above 80% compliance rate for the presence of a completed depression screen in the chart represents a significant improvement. Staff are still concerned about several characteristics of the screen. For example, veterans may have a hard time assessing their response to the item "My sleep was restless" if they get up frequently in the night to urinate. Patients have also commented about the strange sequencing of statements with four negatively worded items followed by "I felt hopeful about the future." Although no additional change is planned, there is continued interest in learning about others' experiences with different tools and protocols.

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ANOTHER APPROACH TO DEPRESSION SCREENING

At the Sheridan (WY) VAMC, the depression screen--labeled "Mental Health"--is completed by patients as part of a larger preventive health screening. A nurse reviews the results with each veteran and makes arrangements for needed referrals. In addition to the two screening questions*, patients are also asked both if they would like mental health counseling and if they want an appointment. Staff experience suggested that some patients said they wanted counseling but did not actually want an appointment.

Contact: Cynthia Edwards, BSN, Utilization Management Coordinator, Sheridan (WY) VAMC; COM 307/672-1964; FTS 700/329-3964.

MENTAL HEALTH

During the past month, have you often been bothered by feeling down, depressed or hopeless?
____Yes ____No
During the past month, have you often been bothered by little interest or pleasure in doing things?
____Yes ____No
If you answered yes to one or both of the above questions, would you like mental health counseling?
____Yes ____No
Would you like to be scheduled for an appointment for mental health counseling?
____Yes ____No

**Whooley, MA , Avins, AL, Miranda, and Browner, WS. (1997) Case-finding instruments for depression: two questions are as good as many. Journal of General Internal Medicine. 12(12): 439-445.*

HOW DO WE KNOW PATIENT EDUCATION WORKS?

HEALTH LITERACY

This cross-sectional survey estimated the prevalence of low functional health literacy among community dwelling Medicare enrolles in a national managed care organization. Functional health literacy was measured using the Short Test of Functional Health Literacy in Adults based upon actual materials that patients might encounter in a health care setting-- prose passages written at 4.3 and 10.4 grade levels and directions from hospital forms and prescription vials. The test is available in both English and Spanish versions. Overall, 33.9% of English speaking and 53.9% of Spanish speaking respondents had inadequate or marginal health literacy. Reading ability declined dramatically with age even after controlling for years of education and cognitive impairment. (Appearing in the same issue of JAMA is a report on Health Literacy from the AMA Council on Scientific Affairs that examines the scope and consequences of poor health literacy in the

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PLAN FOR SEPTEMBER 1999 HEALTH OBSERVANCES

(Materials available from sponsoring organizations)

Cold and Flu Campaign
800/LUNG-USA

Cholesterol Education Month
301/251-1222

Sickle Cell Month
800/421-8453

Sobriety Checkpoint Week(1-7)
800/GET-MADD

National Rehabilitation Week(12-18)
717/341-4637

National 5 a Day Week (12-18)
301/496-8520

For a complete list of national health observances by month and contact information go to the National Health Information Center's web site at < http://nhic-nt.health.org/pubs/ > or call to order a single copy of the associated publication at 800/336-4797.

HEALTH LITERACY *Continued from page 3*

United States.)

Gazmararian, JA. et al. (1999) Health literacy among Medicare enrollees in a managed care organization. JAMA. 281(6): 545-551.
Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association. (1999) Health literacy. JAMA. 281(6): 552-557.

PATIENT EDUCATION/PRIMARY

EFFECTS OF PROGRESSIVE RESISTANCE TRAINING ON BONE DENSITY

A 1999 review of nearly two dozen cross-sectional and longitudinal studies shows overall a direct positive relationship between resistance training and bone density. The authors suggest that such training in contrast to pharmacological or nutritional approaches for improving bone health in older adults also can improve strength and balance and increase muscle mass. A companion article provides exercise training guidelines for the elderly.

Layne, JE and Nelson, ME (1999) The effects of progressive resistance training on bone density: a review. Medicine & Science in Sports & Exercise. 31(1): 25-30.
Evans, WJ (1999) Exercise training guidelines for the elderly. Medicine & Science in Sports & Exercise. 31(1): 12-17.

CARE PROGRAM NOTES

Kiosk Offers Practical Information on Alternative and Complementary Therapies

The Fountain of Healthy Living Learning Center at the Albuquerque VAMC is using the VitaTouch™ module for the HealthTouch™ kiosk as a patient education resource for complementary and alternative medicine including natural remedies for health conditions, herbal remedies, diets and therapies, nutritional supplements, homeopathic remedies, and drug/nutrient interactions. Staff and volunteers in the center use the kiosk as a self-service option for patients and visitors to access information on their own. Patient Health Education Coordinator Carol Maller observes that "this is the only computer I have seen that does not intimidate patients with minimal computer skills. Once users are introduced to the touchscreen, they are eager to make their own choices and pursue information seeking independently." This frees staff to respond to other educational needs and adds an element of privacy to an individual's search. A printer located within the kiosk enables users to print out any article they choose.

Covering more than 500 topics, the articles are based on reviews of scientific and medical journals and include information on sources, potential uses, side effects, contraindications, and references for diverse topics from a wheat free diet to echinacea to homeopathic remedies for restless leg syndrome. Educators have found the data base especially useful because clinicians are not all well-versed in a full range of alternative and complementary therapies. The articles can provide consistent and current information that patients can take back to their primary care providers for discussion. During a recent visit by the JCAHO VISN Liaison to the Albuquerque Learning Center, staff were able to incorporate this feature into their tour as another resource for drug/food interactions with herbal remedies. It was so well received that patient education staff plan to build it into their upcoming JCAHO survey as they showcase resources for patient information.

Contact: Carol Maller, MS, RN, CHES, Patient Health Education Coordinator, VAMC Albuquerque, NM COM 505/265-1711, Ext. 4656; FTS 700/572-4656.

Dental Hygiene Education Contributes to Effective Self-Management of Chronic Conditions

Observing the number of veterans with diabetes, hypertension and/or cardiovascular disease referred into the dental clinic with poor oral hygiene and gum disease, hygienist Patricia Gushin at the El Paso VA Health Care Center has begun a weekly Periodontal Maintenance Class. The purpose

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is to help those with chronic diseases improve self-management of their diseases and reduce the risk of severe gum disease and tooth decay. For example, many diabetics she sees don't understand the link between their disease and problems with their mouth and teeth. In this class they review information about the increased risk of infection for people with diabetes; this enables them to understand that if the amount of bacteria in their mouth grows because they are not properly brushing and flossing, then they are likely to have more gum infections.

For those patients with hypertension and cardiovascular disease, prescribed medications often result in a decrease in mouth saliva which also can have a negative effect on teeth. The drier the mouth, the more the bacteria will thrive. Also, saliva dilutes the acid that is formed by bacteria breaking down food in the mouth and thus reduces the likelihood of tooth decay. Use of saliva substitutes, which can be bought over the counter at a drugstore, can reduce this problem.

As referrals are made to the hygienist, 6-8 veterans are scheduled for the class biweekly or monthly as scheduling allows. In addition to reviewing the basics of good oral hygiene and the special problems of chronic disease, she also focuses on the importance of diet in maintaining healthy gums and teeth. Many of her patients, however, are elderly, living alone, and poor and thus have difficulty eating a balanced diet on a regular basis. A referral to the dietitian may be warranted if the nutritional problem is severe. She also encourages group discussion in the class and individual discussion in follow-up appointments about the question "What would have to happen to get your gums in a healthy state?" This brings up problems that individuals have with brushing and flossing such as a lack of manual dexterity or the size of their hands. Smaller tooth-brushes, electric toothbrushes, toothpicks, and superfloss are demonstrated as possible solutions.

While there has been no formal evaluation of the program, there are signs that a substantial percentage of the patients are making improvements. When the veterans come back to the hygienist for cleaning, she uses the plaque index to rate how much plaque is on the teeth and the gingival index which measures how quickly the gums bleed when probed. Many have less plaque and bleeding.

Since only veterans who are 100% disabled are referred to the dental clinic, Ms. Gushin has been asked by the dietitian to contribute to the diabetic classes on nutrition. She also participates in the weight reduction class since many of these patients also have diabetes. This enables her to see many veterans who she would never see in her clinic, provide them with basic education about oral hygiene, and encourage those who have severe mouth symptoms but good oral hygiene to return to their primary care physicians for further examination. Gum and tooth problems in a person with diabetes who regularly brushes and flosses may signal poor control of the disease.

For more information contact Patricia Gushin, RDH, AAS, registered dental hygienist, El Paso (TX) VA Health Care Center , COM 915/564-7941; FTS 700/564-6100.

"Enhancing Patient Education Skills" Workshops in Chicago Reach Primary Care Clinicians.

Since 1991 an informal collaboration among Chicago VAMCs--Hines, West Side and Lake Side (latter two merged into the Chicago Health Care System with two divisions)--have sponsored annually three "Enhancing Patient Education Skills Workshops." Offered to a multidisciplinary audience, this workshop helps inpatient and primary care staff prioritize educational needs and select teaching techniques that can be effective in short visits. Establishing a helping relationship is stressed as a basis for successful patient education practice.

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Practical strategies for facilitating behavior change--whether that be measured by mastery of a technical skill, adoption of a lifestyle change, or coping with chronic illness--are practiced.

Two faculty from each site participated in the original train-the trainer program through the Cleveland REMC prior to offering the program in Chicago. Three of the original faculty plus four new members meet regularly to plan the yearly series of workshops that rotate among the three sites. While many VAMCs have found it increasingly difficult to continue this 2-day program because of staff time constraints, the Chicago partnership has enabled the program to flourish and reach an additional 90-100 clinicians per year. First, each site is given 10-12 slots to fill for each workshop so that the optimum participation of 30-35 clinicians is met; recruitment of this number three times a year is more manageable than 30 from one site at a time. Second, the logistics for each workshop are managed by the faculty affiliated with the site where the workshop will be offered; this reduces the time that any one faculty member must commit per year.

The benefits of this collaboration go beyond the important outcome of having more clinicians more skilled in interdisciplinary patient education practice. At the end of the workshop, each participant is asked to set a realistic objective and timeline for a project or change in practice relevant to his or her practice setting. Multiple beneficial changes have evolved from these action plans including revisions of key patient education materials to lower reading levels, development of improved educational assessment tools, and broader use of specific techniques-- such as contracting--within already existing programs. In addition the regular planning meetings have encouraged networking among the three sites about patient education related issues and the development of other collaborative projects such as the design of an outcome monitoring system.

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NEW Feature:
Performance Improvement Training

MOTIVATIONAL INTERVIEWING: Tools to Encourage Behavior Change --The Diabetes Example

Every quarter, Patient Education in Primary Care will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit choose one of the following two options:

Read the attached summary "Motivational Interviewing: Tools to Encourage Behavior Change" and provide brief answers to the following questions. Turn these in to your supervisor along with the content description. OR

Organize a one hour brown bag journal club or set aside time during a staff or team meeting to read the original article--*Stott, NCH, Rollnick, S, Rees, MR, and Pill, RM (1995) Innovation in clinical method: diabetes care and negotiating skills. Family Practice. 12(4): 413-418.*--and discuss the following questions. Turn in a master list of journal club participants along with the content description.

QUESTIONS:

1. How do you think these tools could be useful helping patients with diabetes to implement behavior changes?
2. How would you use these tools with patients who have other chronic diseases or health behavior problems?
3. What would be the barriers for staff in utilizing these tools?

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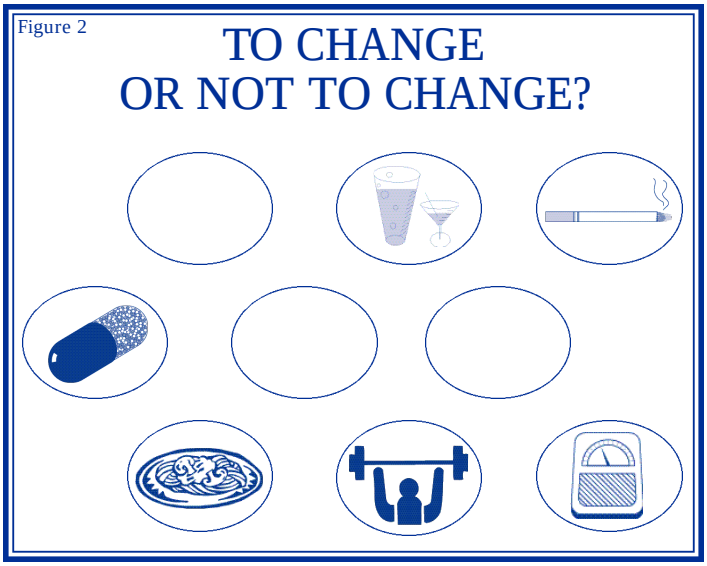
SUMMARY: Motivational Interviewing: Tools to Encourage Behavior Change--The Diabetes Example[3]

There is substantial evidence that encouraging patients to be as active as possible in making decisions about self-management and lifestyle behaviors is positively related to their making actual changes. However, this strategy requires that clinicians allow patients to decide what behaviors to discuss and when change is possible and to identify specific targets that are achievable in the short-run. The role of the clinician then becomes that of a facilitator rather than a persuader or didactic teacher. In order to help providers maintain this facilitator role specifically with diabetic patients, a series of support materials have been developed. Given the nature of chronic disease, these tools are likely to be applicable to a broad array of diagnoses.

The Agenda Setting Chart

The 'Agenda Setting Chart' (Figure 2) provides a visual set of options for discussion and priority setting at each consultation. Literacy is not required and the blanks serve as cues to other factors that may be more important to the individual patient. The chart can be printed as a tear sheet for easy use in examination rooms or blown up poster size. A clinician using this chart with a patient should encourage the patient to clarify the factors that are important to him/her, select a priority, explain why it is important, and set a modest target for the chosen behavior. It is important for the clinician to respect the right of the patient to decide that a factor is either not important or not possible to change at the moment. If the patient is not able to identify any relevant factors, the clinician might ask if there is interest in more information about any of the items on the agenda setting chart.

Figure 2



The Readiness to Change Ruler

If the patient expresses ambivalence about whether or not he or she is ready to change or even talk about possibilities of change, the clinician may be able to use the 'Readiness to Change' Ruler as a teaching tool (Figure 3). This tool can be easily made the size of a ruler, laminated, and kept in examination and/or counseling rooms for easy access. In a discussion in which a patient is probably not ready to set a weight target, use of the ruler may clarify how the individual feels. For example, "You sound as though setting a goal to lose weight is not really an option today. Some people find it easier to describe their feelings on the 'Readiness to Change Ruler.' Where on the scale would you put yourself regarding losing weight?" If the patient is ready or nearly ready then it makes sense to proceed to setting specific targets. If he or she is not ready, then the topic might be dropped until the next visit. If the patient is unsure, the clinician might switch to the use of the 'Pros and Cons Chart.

Figure 3

NOT READY			UNSURE			READY

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[3]*The following information is summarized from the following journal article-Stott, NCH, Rollnick, S, Rees, MR, and Pill, RM (1995) Innovation in clinical method: diabetes care and negotiating skills. Family Practice. 12(4): 413-418. The figures are reprinted by permission of Oxford University Press.*

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Pros and Cons Chart

Ambivalence can be a very time consuming problem to address; however use of a 'Pros and Cons Chart' may help the patient to move up or down on the readiness scale. The clinician encourages the patient to evaluate the possible change in terms of its pros and cons. This can be done during the visit or the patient could be asked to do it before the next visit with a spouse at home or a friend in the neighborhood. Again simple tear sheets with a space for the behavior at the top and two columns--one for pros and one for cons can be printed and made available in exam rooms. Once the list has been created this should provide options for additional discussion of the barriers to change. Patients might be asked to explore some of these barriers such as whether a friend or family member would be interested in a daily walk. As with the other tools, the urge to push the patient in a desired direction should be restrained in order to allow the patient to move at his or her own pace. This may mean taking very small steps at each visit.

COMING IN OCTOBER — JCAHO UPDATE

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.

Do you have any successful patient education strategies that you would like to share with us?

Contact Barbara Giloth (773/743-8206 or email bgilot1@uic.edu), Carol Maller (700/572-2400, ext 4656 or email maller.carol@albuquerque.va.gov) or Charlene Stokamer (700/662-4218 or email stokamer.charlene@new-york.va.gov) with your input!

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